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	AL11943041	**03/09/2018**
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Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to maintain the employment status of all employees within the Background Screening Clearinghouse, including initial employment status and any changes in status within 10 business days.

Findings included:

During record review,on . . . . for the Employee Listing provided by the Assisted Living Facility Manager it was revealed the roster was not kept up to date. There were employees listed that no longer worked at the facility.

The administrator was shown and reviewed names of employee who were no longer working at the facility but were still listed. The administrator confirmed that the roster was not correct or up to date.

Unclassified

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0000 - Initial Comments

Assisted Living Facility (ALF)

A complaint investigation (CCR#: 2018003103, CCR#: 2018002208, and 2018000692) was conducted at Baytree Lakeside Assisted Living Facility (ALF) on . Baytree Lakeside ALF had deficient practice at the time of the visit.
(License#: 6773)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to obtain completed Agency for Healthcare Administration Health Assessment Forms 1823 (AHCA 1823) with all required information to assist in the determination of the appropriateness of the residents' admission and continued stay for eight residents (#3, #4, #7, #9, #10, #13, #15, and #16) of nine sampled residents.

Findings Included:

A record review for Resident #3 conducted on , revealed that Resident #3's most current AHCA 1823 dated did not include the resident's height or weight. Resident #3's AHCA 1823 did not list medications or have the medication list attached.

A record review for Resident #4 conducted on , revealed that Resident #4 had a significant change-in-condition necessitating the need for Hospice admission. Resident #4's most current AHCA 1823 dated did not indicate hospice services for the resident. Resident #4's AHCA 1823 did not list medications or have a medication list attached.

A record review for Resident #7 conducted on , revealed that Resident #7's most current AHCA 1823 dated did not include the type of assistance needed for medication.

A record review for Resident #9 conducted on , revealed that Resident #9's most current AHCA 1823 dated did not include the type of assistance needed for medication.

A record review for Resident #10 conducted on , revealed that Resident #10's most current AHCA 1823 dated did not include whether Resident #10 is free from communicable ; is bedridden; has pressure sores; poses a danger to self or others; or requires 24-hour nursing or care. Resident #10's AHCA 1823 did not list medications or have a medication list attached.

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Resident #10's AHCA 1823 did not include the type of assistance needed for medication.

A record review for Resident #13 conducted on , revealed that Resident #13's most current AHCA 1823 dated did not list medications or have the medication list attached.

A record review for Resident #15 conducted on , revealed that Resident #15's most current AHCA 1823 dated did not list medications or have the medication list attached.

A record review for Resident #16 conducted on , revealed that Resident #16's most current AHCA 1823 dated did not list medications or have the medication list attached.

During a staff interview with the Director of Nursing conducted on at 03:00pm, the Director of Nursing acknowledged and confirmed that residents' AHCA 1823s were incomplete and did not contain all of the required information. The Director of Nursing stated that, "we will have to get new ones."

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to: (1) obtain a completed and up-to-date Agency for Healthcare Administration Health Assessment Form 1823 (AHCA 1823); and, (2) obtain an interdisciplinary care plan for one Hospice Resident (#4) of one sampled Hospice resident who had a significant change-in-condition necessitating an admission to Hospice.

Finding Included:

A record review for Resident #4 conducted on , revealed that Resident #4 had a significant change-in-condition necessitating the need for Hospice admission. Resident #4's most current AHCA 1823 dated did not indicate Hospice services in the Nursing/Treatment/ services required. Resident #4's AHCA 1823 did not have medications listed or have a list of medication attached. Resident #4's record did not contain an Interdisciplinary Care Plan specifying those care and services provided by Hospice and those care and services provided by the facility. Resident #4's record did not contain documentation of agreement of continued residency and the interdisciplinary plan of care by all parties. Resident #4 has a diagnosis and history of , portal , and . Resident #4's and behavioral status including agitation and . Resident #4's AHCA 1823 on page 3 states that, "patient is non-complaint and very agitated." Resident #4's AHCA 1823 does not specify to the type of assistance needed for Activities of Daily Living as both boxes are marked

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for independent and supervision needed for ambulation, dressing, bathing, toileting, and transferring. Resident #4 had four from through . There was no indication in Resident #4's record that all parties (physician, hospice, and resident's responsible party) were notified with each .

During a staff interview with the Director of Nursing conducted on at 03:00pm, the Director of Nursing acknowledged and confirmed that Resident #4's AHCA 1823 was incomplete and did not contain all of the required information. The Director of Nursing stated that, "we will have to get new ones." No Interdisciplinary Care Plan was provided.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview, the facility failed to provide necessary care and services to meet the needs of the residents admitted to the facility.

Findings Included:

An interview was conducted on with the 11:00pm employee who stated the reason staff get the residents up early was that some resident require two people to assist. The second shift does not usually have two staff on. The staff start to get residents up at 6:00am. The residents are brought to the television wait until they go for breakfast at 8:00am.

During an interview with Staff A conducted on at 07:50am, Staff A stated that the facility does not have enough staff to supervise and assist residents. Staff A stated that, "I am by myself until the other day staff get here." The facility had a census of 67 in-house resident on the day of survey.

During an interview with Staff A conducted on at 11:25am, Staff A stated that, "it's very difficult trying to work with one resident and another resident is yelling for help" and "we got to wash, dress, and transfer resident and pass medications" and "most of the residents here need two person assist."

During an interview with Staff E conducted on at 09:59am, Staff E stated that there is "enough staff on 11 - 7 shift but the other shifts need more help."

During an interview with Staff A conducted on at 07:52am, Staff A stated that , "they only

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have two staff on ...most residents are two person assist."

During an interview conducted with Resident #2 conducted on at 08:00am, Resident #2 stated that, she lives in the second building of the facility and is independent with her activities of daily living (ADLs). Resident #2 was unsure if anyone (referring to staff) came to check on her or anyone else in that building. Resident #2 stated that she would have to phone the facility if she needed to reach the staff.

During an interview with Resident #18 conducted on at 09:54am, Resident #18 stated that, "the call light doesn't get answered; we have these (pointing at a call pendent hanging around her neck) but no one answers them."

The shower log for several residents shows the same aides documenting showers for the same residents each week. The shower log shows the second shift are assigned resident names that they are to assist with showers but no documentation that the resident received the showers was available.

During an interview with the Director of Nursing conducted on at 02:30pm, the Director of Nursing stated that the "separate building with resident are our more independent residents" and they "will come over here if they need anything" and "for their meds and for meals."

During a record review for Resident #3 conducted on , revealed that Resident #3 has a diagnosis of and . Resident #3 has difficulty with ambulating and Activities of Daily Living. Resident #3 is independent only with eating. All other Activities Resident #3 needs supervision and assistance. Resident #3 resides in , which is in the separated building for the facility's more independent residents.

During a record review for Resident #13 conducted on , revealed that Resident #13 has a diagnosis of , , , , II, and . Resident #13 needs Special Precautions for being an elopement risk. Resident #13 had an altercation with and the nurse practitioner ordered for a evaluation. Resident #13 resides in , which is in the separated building for the facility's more independent residents.

During a record review for Resident #15 conducted on , revealed that Resident #15 has a diagnosis of , , , , , and . Resident #15 has physical limitations due to back pain. Resident #15 needs Special Precautions for being a risk. Resident #15 in independent with Activities of Daily Living for dressing, eating, toileting, and transferring.

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Resident #15 needs supervision with Activities of Daily Living for ambulation and bathing. Resident #15 resides in , which is in the separated building for the facility's more independent residents.

During a record review for Resident #16 conducted on , revealed that Resident #16 has a diagnosis of , , , , , and Mood . Resident #16's and Behavioral Status is alert and oriented times two and is forgetful with some memory . Resident #16 needs Special Precautions for being at risk for , elopement, and exit seeking. Resident #16 needs supervision with Activities of Daily Living for eating because he needs reminders. However, Resident #16 is marked as independent with all other Activities of Daily Living but also needs reminders "often." Resident #16 resides in , which is in the separated building for the facility's more independent residents.

During an interview with the resident care coordinate (aka: Director of Nursing) on at 2:20pm, the coordinator confirmed the staff were getting residents up and showered to wait 2 hours for breakfast. The coordinator confirmed the only documentation available of residents receiving assistance with showers was from the first shift. The coordinator confirmed that the residents named on the shower log needed assistance with showers twice a week and she could not provide evidence that they were receiving their showers.

Class III

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, record review, and interview, the facility failed to provide supervision or assistance with activities of daily living as needed by residents within the facility.

Findings Included:

During an observation conducted on beginning at 07:00am, eight residents were observed up and dressed, but not and were sitting or sleeping in chairs in the common area (television).

During a facility tour conducted on beginning at 07:15am, there was a smell noted toward the end of the hall near . Through the opened , Resident #27 was observed sitting in his wheel chair taking his pull-up off with standing on the floor in front of him. No staff were present.

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During an interview with Resident #21 conducted on at 10:13am, Resident #21 stated that, "my pees all over the floor and it gets all over floor and my bed covers" and "the like ." Resident #21 lives in with Resident #27.

During an interview with Staff A conducted on at 07:50am, Staff A stated that the facility does not have enough staff to supervise and assist resident appropriately. Staff A stated that, "I am by myself until the other day staff get here." The facility had a census of 67 in-house residents on the day of survey.

During a tour of the facility beginning at 7:00 AM, Resident #7 was observed sleeping in a Geri-chair with a tray table sealed closed in front of her. Resident #7's head was tilted downward and was leaning forward but her head was not touching the tray table. Resident #7's right arm was dangling downward over the right side of the chair but not touching the floor. Surveyor woke Resident #7. Resident #7 stated, "I'm tired" and was unable to lift the tray out of her way.

During an interview with Staff A conducted on at 07:52am, Staff A stated that the 11 - 7 shift puts Resident #7 in that chair because, "they only have two staff on ...most residents are two person assist" and "she's a leaner and if she was in her wheel chair, she would forward."

An interview was conducted on with the 11:00pm employee who stated the reason staff get the residents up early was because some residents require two people to assist. The second shift does not usually have two staff on. The staff start to get residents up at 6:00am. The residents are brought to the television wait until they go for breakfast at 8:00am.

The shower log for several residents shows the same aides documenting showers for the same residents each week. The shower log shows the second shift are assigned resident names that they are to assist with showers but no documentation that the resident received the showers was available.

During an interview with Staff A conducted on at 11:25am, Staff A stated that, "it's very difficult trying to work with one resident and another resident is yelling for help" and "we got to wash, dress, and transfer resident and pass medications" and "most of the residents here need two person assist."

An interview with the resident care coordinate on at 2:20pm confirmed the staff were getting

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resident up and showered to wait 2 hours for the breakfast. The coordinator confirmed the only documentation available of residents receiving assist with showers was from the first shift. The coordinator confirmed that the residents named on the shower log needed assistance with showers twice a week and she could not provide evidence that they were receiving their showers.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview the facility failed to honor resident rights to a safe and decent living environment, free of . . . . . The facility failed to treat residents with consideration and respect.

Findings Included:

During an observation conducted on at 07:00am, Resident #7 was sleeping in a Geri-chair with a tray table sealed closed in front of her in the common area of the facility. Resident #7's head was tilted downward and was leaning forward but her head was not touching the tray table. Resident #7's right arm was dangling downward over the right side of the chair but not touching the floor. When awakened for an attempted interview, Resident #7 stated, "I'm tired" and was unable to lift the tray out of her way.

During an interview with Staff A conducted on at 07:52am, Staff A stated that the 11 - 7 shift puts Resident #7 in that chair because, "they only have two staff on ...most residents are two person assist" and "she's a leaner and if she was in her wheel chair, she would forward."

An interview was conducted on with the 11:00pm employee who stated the reason staff get the residents up early was that some resident require two people to assist. The staff start to get residents up at 6:00am. The residents are brought to the television wait until they go for breakfast at 8:00am.

During a facility tour conducted on . . . . . at 07:15am, a . smell was noted toward the end of the hall near . Through an opened , Resident #27 was observed sitting in a wheel chair taking . . . . . pull-up off with standing . . on the floor in front of him.

During an interview with Resident #21 conducted on . . . . . at 10:13am, Resident #21 stated that,

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"my pees all over the floor and it gets all over floor and my bed covers; the like ." Resident #21 and lives in with Resident #27.

During observations conducted on beginning at 7:00 AM, revealed a storage the door propped open and four large and two small portable tanks. One large tank and two small tanks were not in a secure rack or holder. One of the small tanks was tipped over and leaning. An uneven floor near the 300 , two different flooring types meet at different elevations present as a trip/ hazard See Photographic Evidence1). Linoleum arching upward in main walkway near 300 present as a trip/ hazard (See Photographic Evidence1). Linoleum peeling away from backing does not present as homelike environment and is a potential trip/ hazard (See Photographic Evidence2). A Geri-chair and tray table in remained dirty most of the day and the dirty tray table was lying on a resident's bed/linens. Also in , a crumpled with drying was found lying on a chair for most of the day. Also in , the bottom sheet and the bottom bed sheet had what appeared to be dried , which was never changed during the survey.

A review of the facility's Storage Policy and Procedure (P&P) conducted on , revealed that the facility failed to follow it's own P&P as it stated that, "all shall be stored inside holder racks when not in use; and, should be picked up after it's no longer in use or needed."

During an interview with the resident care coordinator (aka: Director of Nursing) on at 2:20pm, she confirmed the staff were getting residents up and showered to wait 2 hours for breakfast. The coordinator confirmed the only documentation available of residents receiving assistance with showers was from the first shift. The coordinator confirmed that the residents named on the shower log needed assistance with showers twice a week and she could not provide evidence that they were receiving their showers.

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observation, record review, and interview, the facility failed to have available staff to assist resident with self-administration of medications (meds), verbally prompt a resident to take meds as prescribed, follow universal precautions during a medication (med) pass, and inform the resident's health care provider of a resident's non-compliance with medications.

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Findings Included:

During an observation conducted on at 07:15am, revealed that Staff A was the only staff on duty as the only two eleven to seven shift employees left the building and no other direct care staff were on duty. The facility had a resident census of 67 residents on the day of survey.

During the start of a medication (med) pass observation conducted on at 07:50am through 08:10am, all three med carts had dried spills and dust on the tops and base. Staff A did not wash or sanitize her hands at any time throughout the med pass. There was no hand sanitizer available for use near or around any of the three med carts.
At one point, Staff A left the med during the med pass leaving medications unsecured. Staff A was the only staff on duty for a facility census of 67 residents tending to resident care needs and medications . Three residents were inside the med several others were lined up in the narrow hallway to the left and right of the med . During the med pass, multiple complaints of waiting for meds from residents were overheard.

During a med pass observation for Resident #5 conducted on at 07:50am, Resident #5 was not offered prescription inhaler. Staff A documented that this med was given to Resident #5. Staff A did not wash or sanitize hands before or after giving Resident #5 meds. For Resident #5's med , the pills in the pill pack (32 pills) did not match the count sheet (31 pills). For Resident #5 med , the pills in the pill pack (6 pills) did not match the count sheet (13 pills). Another pill pack contained 5 pills but there was no count sheet for this med.

During a med pass observation conducted on at 08:00am, Resident # 11 was overheard hollering from down the hall. Resident #11 was upset that he did not receive his meds that were scheduled for 06:00am. There was no documentation on the Medication Observation Record that these meds had been given.

During a staff interview with Staff A conducted on at 08:01am, Staff A stated that the 11 - 7 shift "worked short" last night and "he was supposed to walk up here and get his meds and if he don't, then it on the 7 - 3 shift to give him his meds."

During a med pass observation for Resident #12 conducted on at 08:03am, Staff A did not wash or sanitize hands before or after giving Resident #12 meds. After Resident #12 used the prescribed , nasal spray, Staff A placed it back on the med cart without cleansing the nozzle.

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During a med pass observation for Resident #6 conducted on [redacted] at 08:05am, Staff A did not wash or sanitize hands before or after giving Resident #6 meds.

During an interview with Resident #18 conducted on [redacted] at 09:54am, Resident #18 stated that, "there's a lot of [redacted] when we have to go to the med [redacted] get meds; it's so crowded and people bump into you while you are just sitting there waiting."

During a Staff interview with Staff A conducted on [redacted] at 11:25am, Staff A stated that, "It's very difficult trying to work with one resident and another resident is yelling for help" and "we got to wash, dress, and transfer residents and pass meds."

During a Staff interview with Staff D conducted on [redacted] at 11:45am, Staff D stated that, "I feel overwhelmed to do my job especially during med pass times."

A Controlled Substance Policy and Procedure (P&P) review conducted on [redacted], revealed that the facility failed to follow own P&P. The P&P states that:
"It shall be the policy of this facility to keep count of all [redacted] given in this facility on a controlled substances record. Each [redacted] prescription received in this facility will have a controlled substance record started, and each time a controlled substance is given it must be signed out on the controlled substance record. Each off-going medication [redacted] /CNA will count [redacted] with th on-coming [redacted] /CNA. If the [redacted] count is not correct, the off-going [redacted] /CNA may not leave the facility until the [redacted] count is correct. Also, NO ONE is permitted access to the med cart, except for the Medication [redacted] / CNA who is designated to pass medications on that [redacted] shift."

A Medication Observation Record (MOR) Audit for Resident #23 conducted on [redacted], revealed that Resident #23 refused meds multiple times, as the initials in the MOR were circled (See Photographic Evidence5). There was no explanation on the back or MOR and no indication that the physician was notified regarding the refusals.

During a [redacted] Audit for Resident #26 conducted on [redacted], Resident #26's [redacted] (bedtime dose) was off-count. The [redacted] pill pack contained 9 pills. The [redacted] count sheet indicated that Resident #26 should have 10 pills (See Photographic Evidence5). Resident #26's [redacted] (morning dose) was off-count. The [redacted] pill pack contained 30 pills. The [redacted] count sheet indicated that Resident #26 should have 29 pills (See Photographic Evidence 5).

During a staff interview with the Director of Nursing (DON) conducted on [redacted] at 03:00pm, the

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DON acknowledged and confirmed that Medication Technicians should be washing and/or sanitizing their hands between residents during a med pass and that it is "never acceptable to leave meds unsecured." The DON agreed that the physician should be notified with med refusals and refusals should be documented on the back of the Medication Observation Record.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the facility failed to keep all centrally stored medications (meds) secured in a locked cabinet, locked cart, or other locked storage receptacle at all times.

Finding Included:

During a med pass observation conducted on beginning at 07:55am, there were three residents inside the medication (med) with Staff A while several other residents were lining up in a narrow hallway with the med opened. The refrigerator in the med many residents' prescription medications including and did not have a locking mechanism. The treatment cart in the med many residents' prescription medicated creams and ointments and was unlocked. Staff A walked out of the med med cart #2 unlocked. Staff A returned to the med 08:00am. Upon return, Staff A ran out of the med to a loud male voice hollering from down the hall. Staff A did not lock the refrigerator, the treatment cart, med cart #2, or the med and two residents continued to wait in the med . Staff A was the only staff on duty at this time. The facility census on the day of survey was 67 residents in-house.

During a med pass observation for Resident #6 conducted on at 08:05am, Staff A was attempting to find a med (Austedo) on Resident #6's MORs. Austedo 9mg (See Photographic Evidence3) fill date was and the last dose should have been given . There were nineteen pills remaining in the package. Staff A placed the medication package back in the med cart.

During a staff interview with the Director of nursing conducted on at 03:00pm, revealed that medications should be locked at all times. The Director of Nursing stated that, "it is never acceptable to leave meds unsecured."

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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview and record review, the facility failed to:
1. Store all prescription drugs with a proper label including the resident's name, identification of medication, and directions of use; and,
2. Obtain a written order for a change in directions for use
for seven residents (#5, #6, #10, #11, #23, #24 and #25) of seven sampled residents who have centrally stored medication (med).

Findings Included:

During a medication (med pass) observation of Resident #5 conducted on at 07:50am, Staff A gave prescribed meds: Loratidine, , Acidophilus, , , , and at this time. All of these meds are scheduled for 06:00am. Staff A did not offer Resident #5 prescribed inhaler that was due at 08:00am. Resident #5 left med receiving the prescribed inhaler. Staff A signed as given on the Medication Observation Record (MOR).

During a med pass observation conducted on at 08:01am, Staff A ran out of med to a loud male hollering from down the hall leaving meds unsecured. Upon Staff A's return to med , Staff A stated that, "that was {Resident #11}; he's mad because he did not get his 06:00am meds; last night they worked short; he's supposed to walk up here and get his meds and if he don't then it on the seven to three shift to give him his meds."

During a MOR Audit for Resident #11 conducted on , revealed that Resident #11's 06:00am meds had not been signed as given.

During a med pass observation for Resident #6 conducted on at 08:05am, revealed that here was no med label on 100mg indicating resident's name, identification of med, and directions for use. Staff A gave one pill to Resident #6. Resident #6's MOR had this med listed. Staff A attempted to find a med (Austedo) on Resident #6's MORs. Austedo 9mg (See Photographic Evidence3) fill date was and the last dose should have been given . There were nineteen pills remaining in the package. Staff A placed the med back in the med cart.

A MOR Audit for Resident #10 conducted on , revealed there was no documentation that Resident #10 received prescribed med , Fumerate on (See Photographic Evidence5). There was no explanation on the back of the MOR as to why the med was held. No orders were found to hold the medication.

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A MOR Audit for Resident #23 conducted on , revealed that Resident #23 refused meds multiple times, as the initials in the MOR were circled (See Photographic Evidence5). There was no explanation on the back or MOR and no indication that the physician was notified regarding the refusals.

During a MOR Audit for Resident #24 conducted on , revealed that on Resident #24 did not receive scheduled 06:00am meds (, , , , , , , , , , Symicort, D3, B1, and) (See Photographic Evidenc5). There was no explanation as to why these meds were held. No orders were found to hold meds.

During a MOR Audit for Resident #25 conducted on , revealed that Resident #25 did not receive meds as prescribed (See Photographic Evidence5) and no explanation as to why meds were held was documented on back of MOR for the following meds:
- on at 08:00pm and at 08:00pm
- Calicium on at 08:00pm and at 08:00pm
- on at 12:00pm, at 12:00pm, at 12:00pm, at 12:00pm and 08:00pm, at 08:00pm, and at 12:00pm
- on at 08:00pm and at 08:00pm
- on at 08:00pm and at 08:00pm
- on at 12:00pm, at 08:00pm, and at 12:00pm
- Laculose on at 08:00pm and at 08:00pm
- on at 08:00pm and at 08:00pm

During a staff interview with the Director of Nursing conducted on at 03:00pm, the Director of Nursing agreed that the medications ordered for specific time should be given at that time within an hour before or an hour after according to practice guidelines. The Director of Nursing stated that explanations should be noted on the back of the MOR if a med is not given.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record review, and interview, the facility failed to be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriated care to all residents as required.

Findings Included:

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During an observation conducted on at 07:00am, eight residents were up and dressed, but not and sitting or sleeping in chairs in the common area (television). Resident #7 was sleeping in a Geri-chair with a tray table sealed closed in front of her. Resident #7's head was tilted downward and was leaning forward but her head was not touching the tray table. Resident #7's right arm was dangling downward over the right side of the chair but not touching the floor. Surveyor woke Resident #7. Resident #7 stated, "I'm tired" and was unable to lift the tray out of her way.

An interview conducted on with the 11:00pm employee who stated the reason staff get the residents up early was that some resident require two people to assist. The second shift does not usually have two staff on. The staff start to get residents up at 6:00am. The residents are brought to the television wait until they go for breakfast at 8:00am.

During a facility tour conducted on at 07:15am, revealed a smell noted toward the end of the hall near . Through opened observed male Resident #27 sitting in wheel chair taking pull-up off with standing on the floor in front of him. No staff present.

During an observation of Resident #9 conducted on at 07:25am, Resident #9 was looking for in the med . Staff present but not assisting Resident #9.

During an interview with Staff A conducted on at 07:50am, revealed that the facility does not have enough staff to supervise and assist resident appropriately. Staff A stated that, "I am by myself until the other day staff get here." The facility had a census of 67 in-house resident on the day of survey.

During an interview with Staff A conducted on at 07:52am, Staff A stated that the 11 - 7 shift puts Resident #7 in that chair because, "they only have two staff on ...most residents are two person assist" and "she's a leaner and if she was in her wheel chair, she would forward."

During a medication observation conducted on from 07:50am to 08:10am, revealed that staff: Leave medications unsecured
- Do not used Universal Precautions
- Do not follow facility policy regarding Controlled Drugs ( )
- Do not give medication when they are scheduled
- Placed a contaminated nasal spray bottle for Resident #12 back in the central storage medication cart (did not cleanse the spray nozzle after use)
- Do not return discontinued medications back to pharmacy
- Do not have labels on all medications indicating the resident's name, the medication and dose, and

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the directions for use

During observations conducted on revealed that the facility does not store safely. Observed in storage door propped open four large and two small portable tanks. One large tank and two small tanks not in a secure rack or holder. One of the small tank was tipped over and leaning. An uneven floor near the 300 , two different flooring types meet at different elevations present as a trip/ hazard See Photographic Evidence1). Linoleum arching upward in main walkway near 300 present as a trip/ hazard (See Photographic Evidence1). Linoleum peeling away from backing does not present as homelike environment and is a potential trip/ hazard (See Photographic Evidence2). A Geri-chair and tray table in remained dirty most of the day and the dirty tray table was lying on a resident's bed/linens. Also in , a crumpled , with drying found lying on sitting chair for most of the day. Also in , the bottom sheet and the bottom bed sheet has what appears to be dried , which was never changed during the survey.

During an interview with Resident #18 conducted on at 09:54am, Resident #18 stated that, "the call light doesn't get answered; we have these (pointing at a call pendent hanging around her neck) but no one answers them."

The shower log for several residents shows the same aides documenting showers for the same residents each week. The shower log shows the second shift are assigned resident names that they are to assist with showers but no documentation that the resident received the showers was available.

During record reviews for Residents #3, 4, #7, #9, #10, #13, #15, and #16 conducted on , revealed that these residents' Agency for Healthcare Administration Health Assessment Form 1823 in which assists in the determination of the appropriateness of residency had omitted required information.

During a record review for Resident #4 conducted on , revealed the facility failed to obtain a completed and up-to-date Agency for Healthcare Administration Health Assessment Form 1823 with a significant change in condition which necessitated Resident #4's admission to Hospice. Resident #4 did not have an Interdisciplinary Care Plan specifying those care and services provided by Hospice and those care and services provided by the facility. Resident #4 record did not contain documentation of agreeance of continued residency by all parties for Hospice services.

During an interview with Staff A conducted on at 11:25am, Staff A stated that, "it's very difficult trying to work with one resident and another resident is yelling for help" and "we got to wash, dress, and transfer resident and pass medications" and "most of the residents here need two person assist."

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During an interview with Staff E conducted on at 09:59am, Staff E stated that there is "enough staff on 11 - 7 shift but the other shifts need more help."

During an interview with Resident #21 conducted on at 10:13am, Resident #21 stated that, "my pees all over the floor and it gets all over floor and my bed covers; the like ." Resident #21 and lives in with Resident #27.

During an interview with the Director of Nursing conducted on at 02:30pm, the Director of Nursing stated that the "separate building with resident our more independent residents" and they "will come over here if they need anything" and "for their meds and for meals."

During an interview with the Director of Nursing conducted on at 03:00pm, the Director of Nursing stated that the residents that live in the separate building are independent residents who do everything for their selves. The Director of Nursing stated that "if they need something, they come over here."

A review of facility Storage Policy and Procedure (P&P) conducted on , revealed that the facility failed to follow own P&P as it stated that, "all shall be stored inside holder racks when not in use; and, should be picked up after it's no longer in use or needed."

During a record review for Resident #3 conducted on , revealed that Resident #3 has a diagnosis of and . Resident #3 has difficulty with ambulating and Activities of Daily Living. Resident #3 is independent only with eating. All other Activities Resident #3 needs supervision and assistance. Resident #3 resides in , which is in the separated building for more independent residents.

During a record review for Resident #13 conducted on , revealed that Resident #13 has a diagnosis of , , , II, and . Resident #13 needs Special Precautions for being an elopement risk. Resident #13 had an altercation with and the nurse practitioner ordered for a evaluation. Resident #13 resides in , which is in the separated building for more independent residents.

During a record review for Resident #15 conducted on , revealed that Resident #15 has a diagnosis of , , , , and . Resident #15 has physical limitations due to back pain. Resident #15 needs Special Precautions for being a risk. Resident #15 in independent with Activities of Daily Living for dressing, eating, toileting, and transferring.

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Resident #15 needs supervision with Activities of Daily Living for ambulation and bathing. Resident #15 resides in , which is in the separated building for more independent residents.

During a record review for Resident #16 conducted on , revealed that Resident #16 has a diagnosis of , , , , , and Mood . Resident #16's and Behavioral Status is alert and oriented times two and is forgetful with some memory . Resident #16 needs Special Precautions for being at risk for , elopement, and exit seeking. Resident #16 needs supervision with Activities of Daily Living for eating because he needs reminders. However, Resident #16 is marked as independent with all other Activities of Daily Living but also needs reminders "often." Resident #16 resides in , which is in the separated building for more independent residents.

During an interview with the resident care coordinator (aka: Director of Nursing) on at 2:20pm confirmed the staff were getting resident up and showered to wait 2 hours for the breakfast. The coordinator confirmed the only documentation available of residents receiving assist with showers was from the first shift. The coordinator confirmed that the residents named on the shower log needed assistants with showered twice a week and she could not provide evidence that they were receiving their showers. At 03:00pm, the coordinator acknowledged and confirmed:

- The medication issues including the omitted documentations, medications being given late, discrepancies, failure to use Universal Precautions during medication pass, unsecured medications, and residents helping themselves to the medication ad lib
- The failure to notify the physician for medication refusals
- The lack of Interdisciplinary Care Plans for Hospice residents for continued residency
- The omissions of required data on the Agency for Healthcare Administration Form 1823s for multiple residents
- The lack of supervision of residents
- The improper use of a for Resident #7
- The facilities frequent documented
- The physical plant safety issues with the flooring being a trip and/or hazard and the unsafe storage of portable tanks

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observations, interviews, and record reviews, notwithstanding the minimum staffing

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requirements, the facility failed to provide enough qualified staff to provide resident supervision and to provide or arrange for resident services in accordance with residents' scheduled and unscheduled service and care needs and resident care standards.

Findings Included:

During an observation conducted on at 07:00am, Resident #7 was sleeping in a Geri-chair with a tray table sealed closed in front of her in the common area of the facility. Resident #7's head was tilted downward and was leaning forward but her head was not touching the tray table. Resident #7's right arm was dangling downward over the right side of the chair but not touching the floor. When awakened for an attempted interview, Resident #7 stated, "I'm tired" and was unable to lift the tray out of her way.

During an interview with Staff A conducted on at 07:52am, Staff A stated that the 11 - 7 shift puts Resident #7 in that chair because, "they only have two staff on ...most residents are two person assist" and "she's a leaner and if she was in her wheel chair, she would forward."

An interview was conducted on with the 11:00pm employee who stated the reason staff get the residents up early was that some resident require two people to assist. The staff start to get residents up at 6:00am. The residents are brought to the television wait until they go for breakfast at 8:00am.

During a facility tour conducted on at 07:15am, a smell was noted toward the end of the hall near . Through an opened , Resident #27 was observed sitting in a wheel chair taking pull-up off with standing on the floor in front of him.

During an interview with Resident #18 conducted on at 09:54am, Resident #18 stated that, "there's a lot of when we have to go to the med get meds; it's so crowded and people bump into you while you are just sitting there waiting."

During a Staff interview with Staff A conducted on at 11:25am, Staff A stated that, "It's very difficult trying to work with one resident and another resident is yelling for help" and "we got to wash, dress, and transfer residents and pass meds."

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During a Staff interview with Staff D conducted on [redacted] at 11:45am, Staff D stated that, "I feel overwhelmed to do my job especially during med pass times."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to provide a clean, safe, hazard-free living, and homelike environment for all residents in the facility.

Findings Included:

During a facility tour conducted on [redacted] at 07:15am, a [redacted] smell was noted toward the end of the hall near [redacted]. Resident #27 was sitting in wheel chair taking his [redacted] pull-up off with standing [redacted] on the floor in front of him.

During an interview with Resident #21 conducted on [redacted] at 10:13am, Resident #21 stated that, "my [redacted] pees all over the floor and it gets all over floor and my bed covers; the [redacted] like [redacted]." Resident #21 and lives in [redacted] with Resident #27.

During an observations conducted on [redacted] revealed that the facility does not store [redacted] safely (See Photographic Evidence1). The storage [redacted] the door propped open four large and two small portable [redacted] tanks. One large tank and two small tanks were not in a secure rack or holder. One of the small tank was tipped over and leaning. An uneven floor was observed near the 300 [redacted], two different flooring types meet at different elevations present as a trip/ [redacted] hazard (See Photographic Evidence1). Linoleum was arching upward in the main walkway near 300 [redacted] present as a trip/ hazard (See Photographic Evidence2). Linoleum was peeling away from backing and is a potential trip/ [redacted] hazard. A Geri-chair and tray table in [redacted] remained dirty most of the day and the dirty tray table was lying on a resident's bed/linens. Also in [redacted], a crumpled [redacted] with drying [redacted] found lying on sitting chair for most of the day. Also in [redacted], the bottom sheet and the bottom bed sheet has what appears to be dried [redacted], which was never changed during the survey (See Photographic Evidence4.)

A review of facility [redacted] Storage Policy and Procedure (P&P) conducted on [redacted], revealed that the facility failed to follow own P&P as it stated that, "all [redacted] shall be stored inside holder racks when not in use; and, [redacted] should be picked up after it's no longer in use or needed."

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During a staff interview with the Director of Nursing conducted on at 03:00pm, the Director of Nursing acknowledged and agreed that the storage is not appropriate or safe and stated that, "we have had a difficult time getting the company to come get the ." The Director of Nursing also agreed that the flooring presents a trip/hazard.

Class III